



Office of Minority Health

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MinorityHealth@doh.state.fl.us

Speakers' Bureau

Speaker's Registration Form

E-mail completed form to MinorityHealth@doh.state.fl.us

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Alternate Telephone Number: _____

Email: _____

Preferred method of contact: Phone _____ Email _____ Best time to contact: _____

Highest degree received: _____ Job Title: _____

Place of Employment: _____

Area(s) of Expertise: _____

Language(s) spoken: _____

Briefly describe presentations topics: _____

Type of group desired (check all that apply):

____ Professional ____ Community ____ K-12 ____ College (specify) _____

____ Roundtable ____ Symposium ____ Other (specify) _____

Cities/Counties/Regions of availability for speaking engagements:

Special skills: _____

Preferred topic(s) for presentations: _____

Do you have a website? If yes, give the URL: _____

Type of presentation (check all that apply):

☐ Discussion/Lecture ☐ Workshop ☐ Keynote ☐ Roundtable ☐ Symposium

Equipment needed from the requesting organization (check all that apply):

<input type="checkbox"/> LCD Projector	<input type="checkbox"/> DVD Player	<input type="checkbox"/> VHS Player
<input type="checkbox"/> Laptop	<input type="checkbox"/> Slide Projector (type: _____)	<input type="checkbox"/> Movie Projector (type: _____)
<input type="checkbox"/> Tape Recorder	<input type="checkbox"/> Projection Stand	<input type="checkbox"/> Projection Screen
<input type="checkbox"/> Overhead Projector	<input type="checkbox"/> Table	<input type="checkbox"/> Blackboard/Chalk
<input type="checkbox"/> Darkened Room	<input type="checkbox"/> Extension Cord	<input type="checkbox"/> VCR/TV Set

☐ Other: _____

☐ Special Request: _____

Length of Presentation: _____ **Set-up time:** _____ **Take-down time:** _____

How did you learn about the Office of Minority Health's Speakers' Bureau? _____

Additional Information or Comments: _____

ATTENTION: Please attach a CV or Biosketch. Also provide a JPEG photo of yourself to be placed next to your biographical sketch.

I agree to release my name and email address to interested groups via the Florida Department of Health, Office of Minority Health's website and that my presentation can be posted on the Office of Minority Health's Website.

Signature: _____ Date: _____

Send this form to back to the State Partnership Grant at MinorityHealth@doh.state.fl.us